Calendar Quarter: Quarter in which Grievances were received.

4th = October – December, 2009 1st = January -March, 2010

2nd = April – June, 2010 3rd = July-September, 2010

Data submission:

4th Quarter, 2009	**Due: January 31, 2010**
1st Quarter, 2010	**Due: April 30, 2010**
2nd Quarter, 2010	**Due: July 31, 2010**
3rd Quarter, 2010	**Due: October 31, 2010**

- Data must be in EXCEL and be submitted electronically through the DSHS HRSA OQCM Secure File Transfer (SFT) (formerly known as Valicert) web site. Submitter must send an upload notification to the DSHS HRSA OQCM mailbox at hrsaoqcm@DSHS.WA.GOV .
- Submissions must be labeled with health plan name, reporting year and quarter, and book of business (Example: Health Plan name Q2/10 & Q3/10 HO/BH+-S Women/SCHIP; WMIP; GAU; MMIP).
- Data must be reported and loaded separately onto the DSHS HRSA OQCM SFT (currently known as Valicert) web site by book of business to ensure compliance with HIPAA privacy requirements.
(Example: HO/BH+-S Women/SCHIP; WMIP; GAU; MMIP).

MCO Format Reporting Guidelines:

1. **Column A**: Health Plan Name – Indicate reporting plan with full name or common abbreviation.
2. **Column B:** Delegated Entity – Identify the health plan's delegated entity that receives denial, appeal, or grievance. The health plan is responsible to integrate the delegated entity's data into the health plan's data. There should be no separate data submission for the delegated entities.
3. **Column C**: Quarter – Indicate the reporting quarter the initial grievance is received. Reporting format: 1,2,3,4
4. **Column D**: Program Name – Specify the program for the data submitted using numbers 1-7 as follows:
    1. BH – Indicates Basic Health and HCTC enrollees,
    2. PEBB – Includes all enrollees covered by the PEBB contract

3. HO – Includes all HRSA Healthy Options Medicaid Managed Care enrollees (also see Column E)
4. BH+ - Includes Basic Health Plus and Maternity Program enrollees
5. SCHIP – Identifies Children's Health Insurance Program enrollees
6. GAU - When applicable to the reporting health plan.
7. WMIP - When applicable to the reporting health plan.

5. **Column E:** ESHCN- Identify all Enrollees with Special Health Care Needs by program with an "X". **(mandatory for HRSA only)**
6. **Column F:** Enrollee ID – Populate column with the enrollee's Social Security Number. (**mandatory for HCA only)**
7. **Column G**: Enrollee Last Name- Identifies the enrollee. (**mandatory for HRSA only)**
8. **Column H**: Enrollee First Name – Identifies the enrollee. (**mandatory for HRSA only)**
9. **Column I**: Enrollee Middle Initial – Identifies the enrollee. (**mandatory for HRSA only)**
10. **Column J:** Enrollee Birth Date – Format: MM/DD/YYYY. (Example: 12/01/1985).
11. **Column K**: Provider/Practitioner Last Name – Identifies the serving provider/practitioner, either as the source of an enrollee's grievance, was the provider of service the plan took action upon or denied, or is addressing the enrollee's service.
12. **Column L**: Provider/Practitioner First Name – Identifies the serving provider/practitioner, either as the source of an enrollee's grievance, was the provider of service the plan took action upon or denied, or is addressing the enrollee's service.
13. **Column M**: Provider/Practitioner Middle Initial - Identifies the serving provider/practitioner, either as the source of an enrollee's grievance, provider of service the plan took action upon or denied, or is addressing the enrollee's service.
14. **Column N**: Provider/Practitioner Category – Identifies type of practitioner. Should be no more than thirty (30) characters.

    Examples: Family Practitioner, Chiropractor, Acupuncturist, Surgeon, General Surgeon, Orthopedist, Urologist, Internal Medicine, Certified Nurse Practitioner, Dermatologist, etc.

15. **Column O**: Facility Name - Identifies the facility or clinic the practitioner is associated or contracted with and which is associated with the grievance, denial/action, or appeal.
16. **Column P:** Type/Level – Specifies the category and the level for the data submitted as follows:

    1= Grievance

    2=Denial (**PEBB**/**BH Only**)

    3=Action **(HRSA Only)**

    4=1st Level Appeal

    5=2nd Level Appeal

    6=Independent Review Organization (IRO)

    7=State Hearing **(HRSA Only)**
17. **Column Q**: Expedited – Identifies urgency of the grievance or appeal. Reporting format: "X" for yes.
18. **Column R**: Grievance, Denial/Action, Appeal, IRO, or Hearing Issue – Identifies/describes the "what" or the catalyst for the requested grievance, the service denied or MCO action taken, or issue driving the appeal by the enrollee or practitioner. **This key descriptive column must be populated for all records.**

    Issue Examples:

    Grievances: Administrative, Referrals, Waited too long on hold (or Dissatisfaction with Quality of Service), Provider was rude (Interpersonal Relationships or Dissatisfaction with Quality of Service), could not access a preferred provider (or Dissatisfaction with Plan Practices).

    Denials/Actions: Pain Management, Durable Medical Equipment, Prescription Drug, Chiropractic Benefits, PT/ST/OT, Emergency Services, Out of Area Care, Psychotherapy, Acupuncture.

    Appeals, IROs, State Hearings: Reflects what was in the initiating Denial/Action.
19. **Column S**: Grievance, Denial/Action, Appeal, IRO, or Hearing Reason: - Describes the "why" or which best describes the reason behind the member's dissatisfaction, behind the denied, reduced, or changed service, or for causing the appeal, IRO, or hearing. **This key descriptive column must be populated for all records.**

    Reason Examples:

    Grievances: Referral lost or incomplete, Staff behavior, Perceived lack of caring/concern.

    Denials/Actions: Not Medically Necessary, Not Medically Indicated, Partial Approval, Not a Covered Benefit, Contract Exclusion, No Benefit, Limited Benefit/Excluded, , Benefit Exceeded/Exhausted, Out of Network, Not A

Contracted Provider, Non-Preferred Provider, Care Available from participating provider, No Referral, RX criteria not met, Investigational/Experimental, etc.

Appeals, IROs, State Hearings: Reflects what was in the initiating Denial/Action.

(NOTE: "Other" category should be used only as a last resort.)

20. **Column T**: Resolution of Grievance, Appeal, or IRO – – Describes the "outcome" – the grievance, appeal, IRO, or State Hearing determination. This specifies all partial approvals or a plan changes in a service request. **This key descriptive column must be populated for all records.**

    Resolution Examples:

    Grievances: Resolved, Forwarded to Admin/Mgr., Explanation Provided, Adjustment Completed, Forwarded to QI, Benefit Explained, Consulted/Advised.

    Appeals, IRO/State Hearing Determinations: Upheld, Overturned, Reversed, Partially Upheld, Partial Payment, Partial Approval, Withdrawn.

21. **Column U**: Date Received – Documents the date the grievance was received, a denial or action took place, or an appeal, IRO, or State Hearing request was received. Reporting format: MM/DD/YYYY

22. **Column V**: Date Resolved – Identifies the date a grievance was responded to, dates denial notice sent, or date an appeal, IRO, or a denial determination is made. Reporting format: MM/DD/YYYY

23. **Column W**: Date written notification sent to enrollee and practitioner. Reporting format: MM/DD/YYYY

Note: Some plans requested examples of denial, appeal, grievance categories and denial reason. Plans are **not** required to use the issue and reason examples listed.

Additional Sample Grievance Issues by Category:

Access
Appointment availability with PCP-Grievance could include such issues as the inability to see a specific PCP; delay in getting an appointment to a PCP; appointment times are inconvenient; inadequate numbers of PCP, location of PCP office is inconvenient.
Appointment availability with specialist – Grievance can cover the same issues as above as they apply to physician specialists.
Appointment availability with ancillary- Grievance can cover the same issues as in above as they apply to ancillary services such as lab, radiology, etc.
Difficulty obtaining referral and/or covered services.
Difficulty obtaining after hours care- no response or delayed response; incomplete or unsatisfactory response to call made to the health plan or practitioner after normal business hours.
Network- adequacy of the practitioner network.

Quality of Care Dissatisfaction with quality of medical care. Dissatisfied with explanation of the problem or issue. Dissatisfied with quality of clinical provider (such as physicians, nurses, therapists, psychologists) and /or such issues as misdiagnosis by any provider, unsatisfactory outcome of the treatment; unsatisfactory treatment methods, tests were not properly done, were lost, results, were not communicated; medical records could not be obtained; medication errors.
Hospital - dissatisfaction with length of stay; dissatisfaction with hospital treatment or discharge plans. Dissatisfaction with substance abuse services/treatment; or dissatisfaction with substance abuse provider. Dissatisfaction with pharmacy - generic drug problem; or the health plan's drug formulary.
Quality of Service Dissatisfaction with provider services (non-medical): The physician or office staff behavior or appearance; office or facility appearance; wait time in the provider's office, exam room, or on the telephone. Dissatisfaction with the health plan's service: Health plan staff behavior, difficulty with telephone access and wait time. Eligibility- issuance and/or receipt of I.D. cards, enrollment, disenrollment. Telephone - Multiple transfers/calls to resolve issue. Reimbursement/billing disputes- billing errors; enrollee is being billed directly; visits to providers are denied payment. Pharmacy - dissatisfaction with length of prescription; dissatisfaction with type/locations of vendors; problem with mail order prescriptions.